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The Addictive & Mental Disorders Division
Community Mental Health Services for Adults – Fall 2011

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This presentation covers:

- Mental Health Services Plan
- MHSP Waiver
- HCBS
- Submitting Claims
- Claims forcing (including Medicaid)

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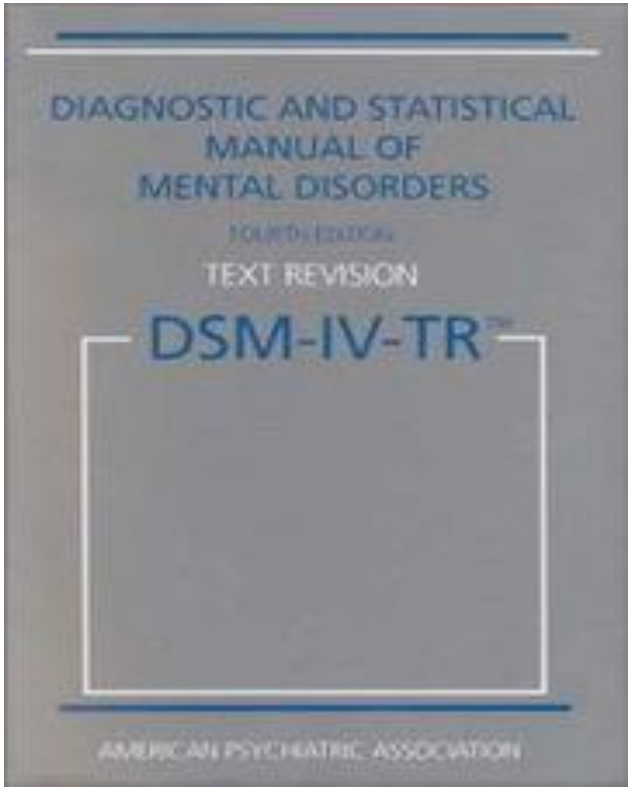
The Mental Health Services Plan



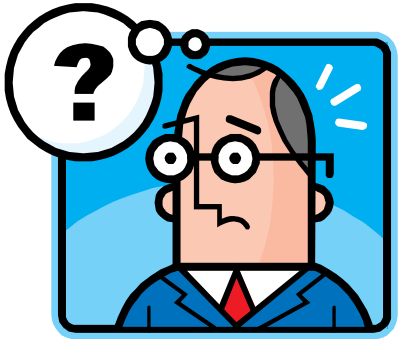
Enrollment in MHSP is limited to individuals who meet:

1. **Financial criteria (falling below the 150% of Federal Poverty Guidelines).**
2. **Meet SDMI criteria.**

Changes in MHSP

First let's talk about what's *NOT* changed…

SDMI criteria <u>has not changed</u>.



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SMDI vs. MI

MHSP COVERED SDMI DIAGNOSES

293.0	Delirium Due to a General Medical Condition
293.81	Psychotic Disorder Due to a General Medical Condition, with Delusions
293.82	Psychotic Disorder Due to a General Medical Condition, with Hallucinations
293.83	Mood Disorder Due to a Medical Condition
294.0	Amnestic Disorder Due to a General Medical Condition
294.8	Amnestic Disorder Not Otherwise Specified
295.10	Schizophrenia, Disorganized Type
295.20	Schizophrenia, Catatonic Type
295.30	Schizophrenia, Paranoid Type
295.40	Schizophreniform Disorder
295.60	Schizophrenia, Residual Type
295.70	Schizoaffective Disorder
295.90	Schizophrenia, Undifferentiated Type
296.22	Major Depressive Disorder, Single Episode, Moderate
296.23	Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
296.24	Major Depressive Disorder, Single Episode, Severe With Psychotic Features
296.32	Major Depressive Disorder, Recurrent, Moderate
296.33	Major Depressive Disorder, Recurrent, Severe Without Psychotic Features
296.34	Major Depressive Disorder, Recurrent, Severe With Psychotic Features

SDMI vs. MI, cont.

296.40	Bipolar I Disorder, Most Recent Episode Manic, Unspecified
296.42	Bipolar I Disorder, Most Recent Episode Manic, Moderate
296.43	Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features
296.44	Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features
296.52	Bipolar I Disorder, Most Recent Episode Depressed, Moderate
296.53	Bipolar I Disorder, Most Recent Episode Depressed, Severe Without Psychotic Features
296.54	Bipolar I Disorder, Most Recent Episode Depressed, Severe With Psychotic Features
296.62	Bipolar I Disorder, Most Recent Episode Mixed, Moderate
296.63	Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features
296.64	Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features
296.7	Bipolar I Disorder, Most Recent Episode Unspecified
296.80	Bipolar Disorder NOS
296.89	Bipolar II Disorder
297.1	Delusional Disorder
297.3	Shared Psychotic Disorder
298.9	Psychotic Disorder NOS
299.80	Asperger's Disorder
299.80	Pervasive Developmental Disorder NOS

SDMI vs. MI, cont.

300.01	Panic Disorder Without Agoraphobia
300.21	Panic Disorder With Agoraphobia
300.3	Obsessive-Compulsive Disorder
301.0	Paranoid Personality Disorder
301.20	Schizoid Personality Disorder
301.22	Schizotypal Personality Disorder
301.4	Obsessive-Compulsive Personality Disorder
301.50	Histrionic Personality Disorder
301.6	Dependent Personality Disorder
301.81	Narcissistic Personality Disorder
301.82	Avoidant Personality Disorder
301.83	Borderline Personality Disorder
301.9	Personality Disorder NOS
309.81	Posttraumatic Stress Disorder
310.1	Personality Change Due to…[Indicate the General Medical Condition]

MHSP, cont.

Has ongoing functioning difficulties because of the mental illness for a period of at least six months or for an obviously predictable period over six months, as indicated by at least two of the following:

(i) a medical professional with prescriptive authority has determined that medication is necessary to control the symptoms of mental illness;

(ii) the person is unable to work in a full-time competitive situation because of mental illness;

(iii) the person has been determined to be disabled due to mental illness by the social security administration; or

(iv) the person maintains a living arrangement only with ongoing supervision, is homeless, or is at imminent risk of homelessness due to mental illness; or

(v) the person has had or will predictably have repeated episodes of decompensation

MHSP CONTRACTS

Effective April 1, 2011, AMDD has contracts with licensed mental health centers that provide services to adults with severe disabling mental illnesses who have been determined eligible for the Mental Health Services Plan.

Regional mental health centers make the determinations and enrollments as of April 1, 2011. Other licensed mental health centers make the determination of eligibility and notify the Benefit Management Team of enrollment.

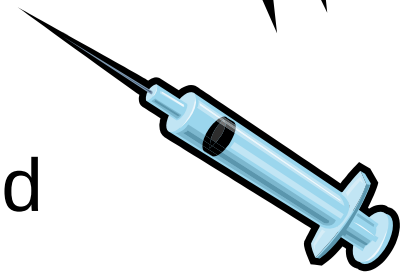
MHSP Contracts

Reimbursement to providers who have prescriptive authority or who provide medication management will continue to be reimbursed on a fee-for-service model.

MHSP Contracts, cont.

The provider types not affected by these amendments include

- physicians,
- psychiatrists,
- mid-level practitioners,
- labs,
- rural health clinics, and
- federally qualified clinics.



MHSP Contracts

Priority enrollment must be given to a qualified applicant who is:

-A patient at Montana State Hospital (MSH) ready for discharge;

-A person experiencing a psychiatric crisis;

-A person with recurrent thoughts of death, recurrent suicidal ideation or suicide attempt, or a specific plan for committing suicide.

Encounter Claims

Report all direct services provided to MHSP adult clients through the Affiliated Computer Services (ACS) claims payment system. ACS is the Department's fiscal intermediary for Medicaid and MHSP.

Eligibility Procedures for other medical providers:

- Screen for financial eligibility. If the individual has no income, complete Zero Income form. Do not do anything else if the person is not financially eligible.
- Individuals with a Medicaid spenddown should include the amount of the spenddown on their application.
- Complete clinical assessment and application form.

Eligibility Procedures

- Fax Clinical and Financial Eligibility Forms to AMDD (406) 444-4435 within two weeks of the initial assessment if the individual is in crisis. Submit within 30 days for all other situations.
- Within two business days, AMDD will determine whether the individual meets priority status for enrollment and notify the provider.
- If additional information is needed, providers will have 5 business days to submit the requested information.

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Eligibility Procedures

- AMDD will produce a letter indicating whether the individual is enrolled, on waiting list, or ineligible. Letters will be mailed to applicants and faxed to providers.

- Applicants may be determined “eligible” but not enrolled. AMDD will maintain a waiting list of eligible but unenrolled individuals.

- Individuals may be enrolled from the waiting list if they are in crisis or at high risk for decompensation or hospitalization.
- Notify the Benefit Management Team if an individual on the waiting list is in crisis.
- Determinations may be appealed.
- Always send additional information to appeal a determination!

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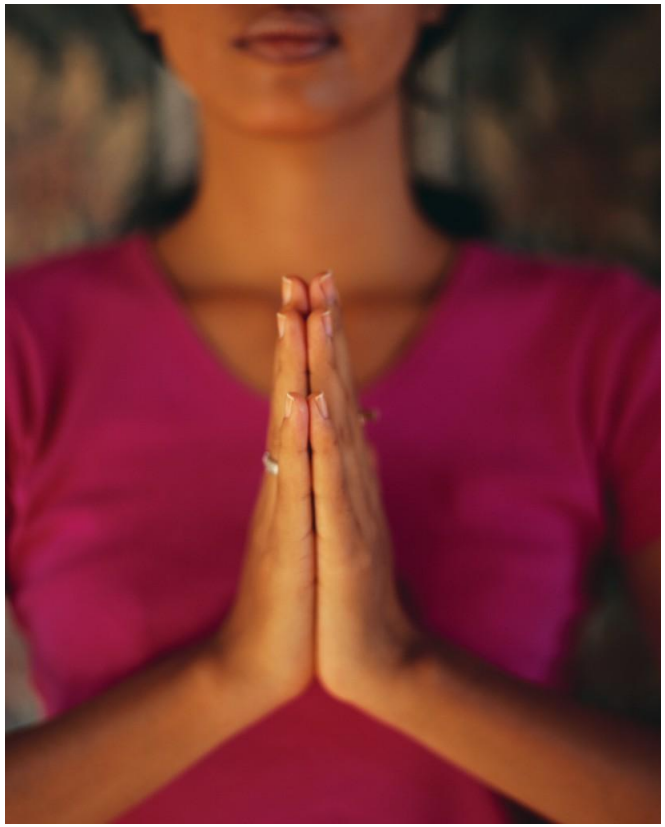
PLEASE check for Medicare eligibility.

- If an individual is receiving a Social Security check and does not have Medicaid, they are probably eligible for Medicare.
- Medicare eligible individuals should enroll in Parts B and D before applying for MHSP.



Informal Reconsideration Process

- Denied claims are subject to an informal reconsideration process.
- Review is conducted by AMDD's Benefit Management Team.
- Written request must be submitted via mail or fax within 30 days of denial.
- Decision communicated by the Benefit Management Team is final.

Renewal

MHSP eligibility is valid for one year.

If renewal is not completed within 30 days of expiration, eligibility will be terminated.

- If the renewal application is received within 30 days following expiration, the renewal will be effective retroactive to the date of expiration, with no lapse in eligibility,
- Otherwise, the renewal will be effective on the date the application was received; there may be a gap in coverage.

Renewal (cont.)

Only financial information is required for standard re-application (i.e., received within 30 days of expiration).

A clinical assessment is not required.

If eligibility lapses for 31 days or more, a new clinical assessment will be required.

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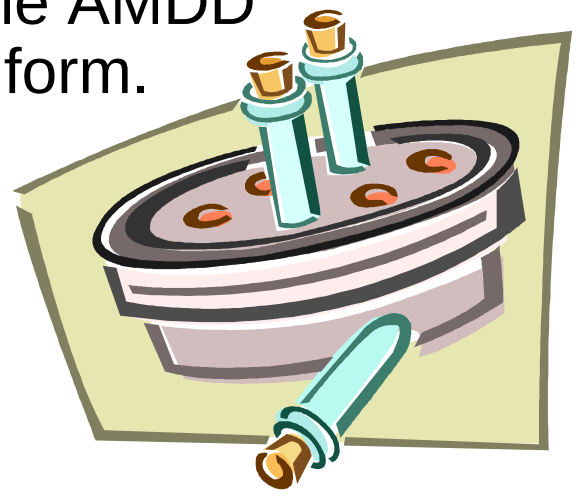
MHSP Laboratory Fees

Laboratory services for management of medications prescribed for mental illness are covered.

Laboratory providers submit these claims to ACS on a CMS 1500 form.

Hospitals must submit these claims to the AMDD Benefit Management Team on a UB-04 form.



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MHSP Application Forms and instructions can be obtained from the following locations:

- The AMDD website:

http://www.dphhs.mt.gov/amdd/services/mhsp.shtml

- AMDD Benefit Management Team
- FQHC/RHC
- Community mental health center

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For more information contact:

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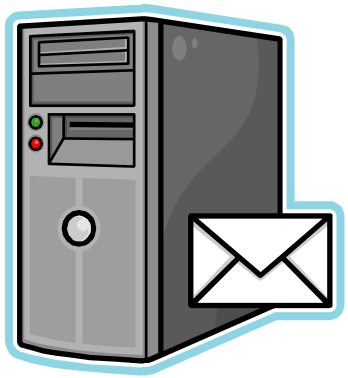

MHSP Waiver

- Started December 1, 2010
- Persons are randomly selected with priority given to persons with Schizophrenia
- 800 slots; almost 550 person have been drawn
- Eligibility
  - 18 years of age and no older than 64 years of age
  - Have primary diagnosis of Schizophrenia or Bipolar Disorder
  - Must be MHSP eligible

MHSP Waiver, cont.

- Receives Basic Medicaid Coverage
- Coverage is for one continuous year
- Can be re-enrolled after the one year provided that the individuals meets all eligibility criteria for MHSP

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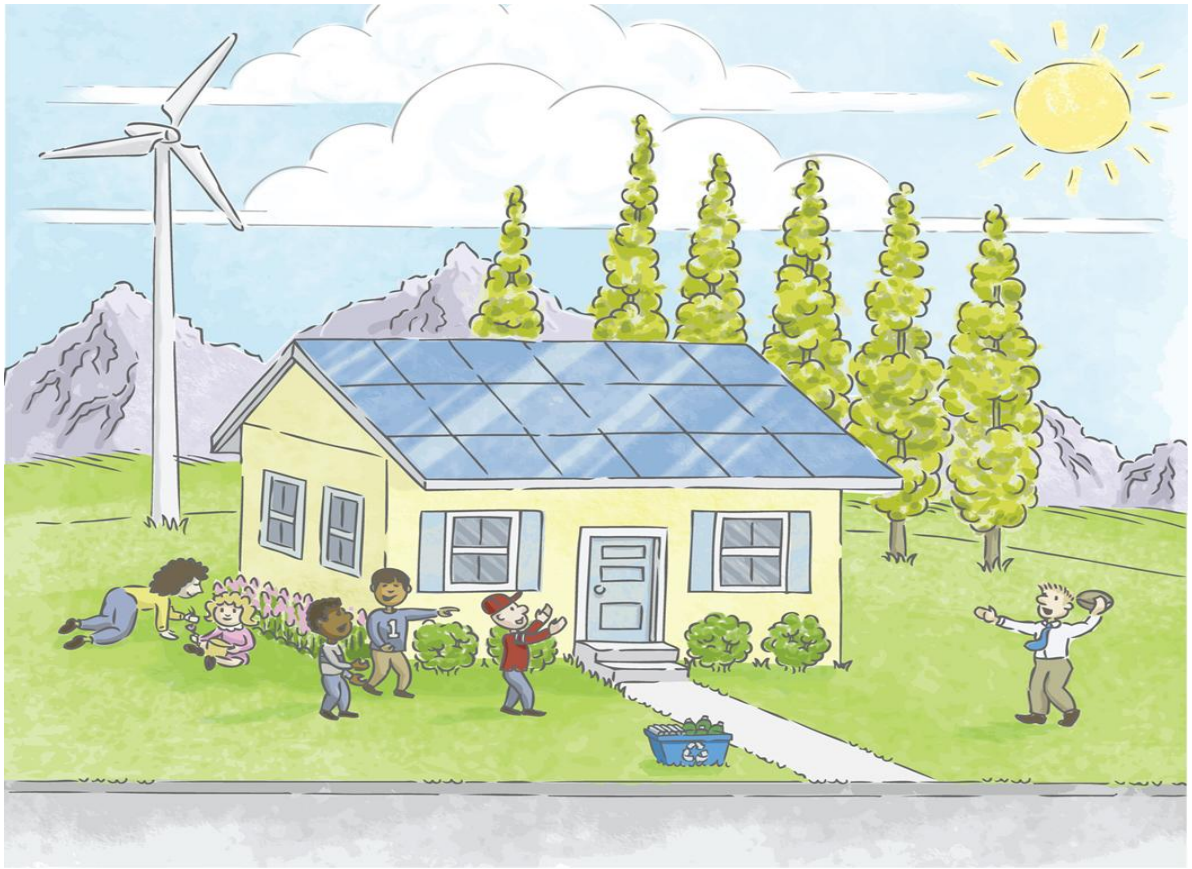
HCBS Waiver:
Home and Community Based Services



HCBS Waiver

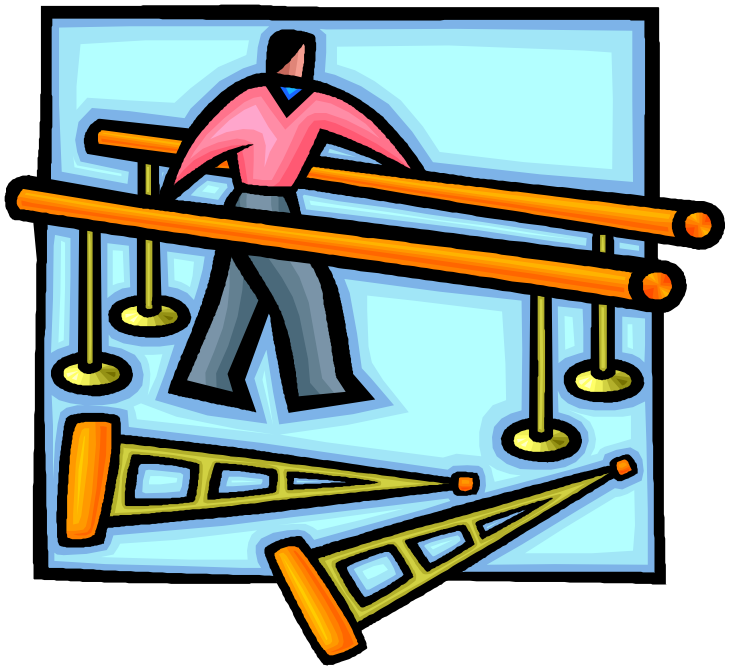
Designed to provide a consumer with SDMI a choice:

1) Receiving long term services in a community, or
2) Receiving long term services in a nursing home setting.

Consumer must meet nursing home level of care and reside in an area of the state where the SDMI Waiver is available.

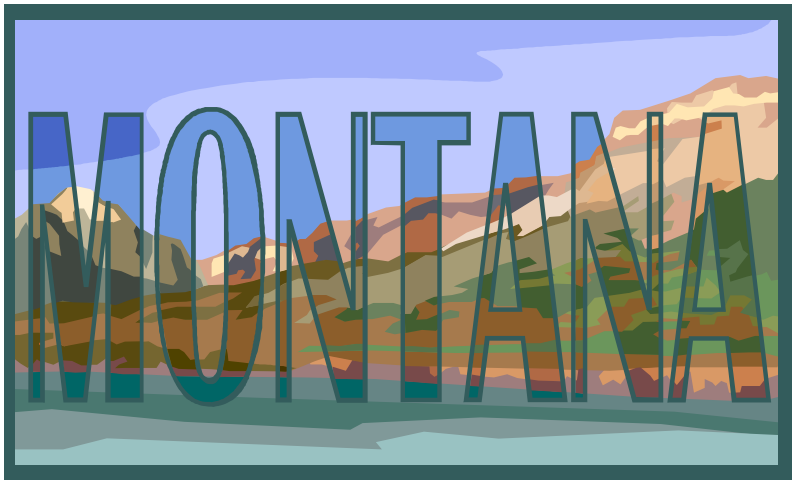
HCBS, cont.

Objective for the program is rehabilitation and recovery.



HCBS Waiver, Cont.

- HCBS providers are enrolled Medicaid providers.
- All payments occur through MMIS.



HCBS Waiver, cont.

Four areas:

1. Yellowstone – counties included: Big Horn, Carbon, Stillwater, and Sweet Grass.
2. Silver Bow – counties included: Beaverhead, Deer Lodge, Granite, Powell, and Jefferson
3. Cascade – counties included: Blaine, Choteau, Glacier, Hill, Liberty, Pondera, Teton, and Toole
4. Missoula county

HCBS Waiver, cont.

Services included in the HCBS Waiver: case management, adult residential care, supported living, adult day health, personal assistance, habilitation, homemaking, respite, outpatient OT, outpatient MH therapy, chemical dependency counseling, dietetic and nutrition counseling, nursing services, personal emergency response systems, durable medical equipment and supplies, non-medical transportation, IMR, and WRAP.

Services are reimbursed as fee-for-service.

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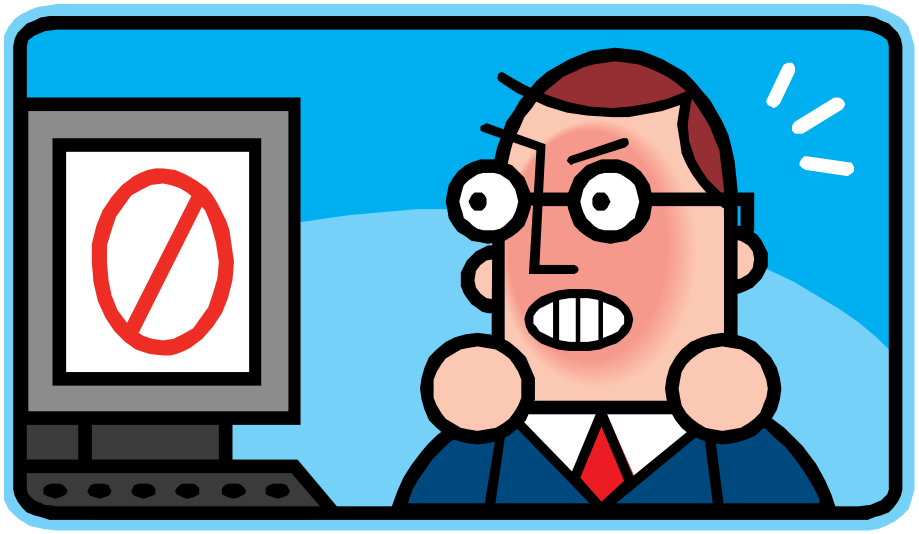
SUBMITTING CLAIMS



PLEASE…..

- Check client eligibility before submitting claims
- Use correct SSN

Please DON'T……

Resubmit a denied claim without fixing it.

If you don't understand why it denied:

1) First, call Provider Relations for help, and if it is not resolved, then
2) Send ICN to AMDD for assistance.

Please DON'T……

- Change a diagnosis so the claim pays.
- Change the amount billed in the hope of getting more money.
- Submit claims with Medicare or TPL without the required documentation.

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When a client has Medicare….

- Claims are denied when the MMIS (Web Portal) does not show Medicare enrollment and the claim includes Medicare information.

- Check Medicare enrollment on the Web Portal prior to submitting claims.

Common Issues Resulting in Denials

- Client has Medicare on file and no Medicare information is present on the claim
- Medicare denied the services as not medically necessary
- Medicare denial reasons are not attached
- Medicare EOB and claim information do not match
  - Check client name, ID, date of service, billed amount, procedure code(s)

- AMDD and ACS recently implemented a systematic process with CMS to verify Medicare information for MHSP enrolled clients.
- Updates are made to the MMIS for Medicare parts A, B and D.
- Providers should notify the Benefit Management Team of Medicare coverage if enrollment does not show in the Web Portal and that information can be added.

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Common Billing Errors

- Non-covered diagnosis in Box 1 or 2 (MHSP)
- Non-covered procedure code
- Client not eligible on date of service
- Client eligible for 72 Hr Program on date of service

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Forcing Claims

Claims we will force:

- Retroactive Medicaid eligibility.
- Claims that denied due to errors that were caused by ACS or AMDD.
- MHSP lab claims for hospitals.

Claims we will not force:

- Claims that are past timely due to billing errors.
- Claims with changed diagnoses or that show physical evidence of being changed.

We will not force:

- Claims that are past timely due to MHSP enrollment errors.
- Claims that do not have required documentation of TPL attached.
- Claims for services that exceed the unit limit on the code or the authorized units.

We will not force:

- Claims for two 90801 assessments by clinicians within your agency that were completed on the same day.
- Claims for a second 90801 during a 72 Hr eligibility span.

We will not force:

- Claims that do not have a correct Medicare EOB attached.
- Claims for an unenrolled Medicare provider.
- Claims that contain billing information that differs from what was billed to other insurance.

Any Questions?